



HENRY F GARAZO MD

PLASTIC SURGERY SERVICES & MED SPA

Welcome to our Office!

Today's Date: _____

Mr. Mrs. Miss Dr. Female Male Other _____

Name: _____ What name to you prefer to be called? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ May we leave a message? YES NO

Home Phone: _____ May we leave a message? YES NO

Work Phone: _____ May we contact you at work? YES NO

Date of Birth: ____/____/____ Age: _____

Email Address: _____ Would you like join our email list? YES NO

Do you have social Media? Facebook Instagram TikTok Other _____

Occupation: _____

Marital Status: (circle one) Single Married Divorced Widowed Domestic Partner

Employer: _____

Employer Address: _____

Family Physician: _____

Phone #: _____ Fax #: _____

Cardiologist (if applicable): _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone #: _____ Work Phone #: _____

I give permission for photographs to be taken before, during, and after my procedure or surgery for the purposes of documentation.

Sign _____

Date _____

I, the undersigned, am aware that I am financially responsible for all services rendered to me by Dr. Garazo and Plastic Surgery Services & Medspa. I am aware we do not accept insurance for cosmetic/elective procedures OR provide CPT Codes for any procedures recommended by Dr. Garazo

I certify that the information I have provided regarding my identity and demographic information is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my health care providers. I permit a copy of this authorization to be used in place of the original.

I, the undersigned, acknowledge that I will be charged a fee of **\$50** for any **medical appointment** or **\$150** for any **cosmetic appointment or cosmetic consultation** that is cancelled without providing at least **twenty-four (24) hours notice**. I further understand that **failure to attend a scheduled appointment without prior notice (no-show)** will result in a charge equal to the full cost of the scheduled service.

In the event of a no-show for a Medical Spa appointment, I understand that I will be charged for the entire amount of the service. In the event of a no-show to a prepaid service, I understand that I forfeit one session.

Patient Signature _____

Date _____

Name: _____ DOB: _____ Today's Date: _____ Chart #: _____
Age: _____ Height: _____ Weight: _____ lbs. _____ inches
Fitz: _____ (PSS Weight: _____ BMI: _____)

Allergies: _____
Reason for today's visit: _____

MEDICAL HISTORY: Please place a Y/N next to each:

LIST MEDICATIONS: (Rx and Over counter medications)

- ___ Skin Cancer (BCC/SCC/Melanoma) Location: _____
___ Heart Problems (heart attack, chest pain, pacemaker, irregular heartbeat)
___ Blood Thinning Medications (Aspirin, Plavix, Coumadin, Warfarin, Aggrenox, Pradaxa, Xarelto)
___ High Blood Pressure
___ Circulation Problems/Ankle Swelling
___ Leg or Lung Clots
___ Stroke, TIA, Seizure
___ Asthma/Shortness of Breath/COPD/Sleep Apnea
___ Anesthesia Problems/Airway Problems/PONV ___ muscle spasms
___ Malignant Hyperthermia, ___ high fever, ___ neuromuscular disease
___ Diabetes (Oral Meds or Insulin)
___ Thyroid Problems (Hyper, Hypo)
___ Cancer (Type: _____ Date: _____)
___ Recent cold/Infection or chronic illness _____
___ Cold sores, Herpes
___ HIV, Hepatitis, Blood Transfusions, Refusal of blood or blood products
___ Mental Health (depression, anxiety, eating disorders, cutting, etc.)
___ High Cholesterol
___ Other _____

FAMILY HISTORY:
What family member:

- Skin Cancer: _____
Melanoma: _____
Breast Cancer: _____
Anesthesia Problems: _____
(Malignant Hyperthermia, high fever, neuromuscular disease)
Bleeding Problems/Clots: _____
Other: _____

SURGICAL HISTORY: (Please put YEAR of surgery)

- ___ Breast biopsy ___ Right ___ Left Breast
___ C-Section
___ Hysterectomy
___ Appendectomy
___ Gallbladder
___ Past Cosmetic Surgery: _____
___ Other Surgery: _____

Smoker? Y or N Started: _____
Amount: _____ /day? Quit: _____

Alcohol Use? Y or N A mount ___/week?
History of IV drug use? Y or N _____

OFFICE USE ONLY:

EXAM ___ HEENT IMPRESSION/PLAN: ___ Heart 1. Schedule
___ Respiratory ___ GI/GU 2. F/U PRN

Notes:



HENRY F GARAZO MD

PLASTIC SURGERY SERVICES & MED SPA

Health Insurance Portability & Accountability Act (HIPAA)

I have been provided with a Notice of Privacy Practices in compliance with HIPAA regulations. I have read and understand my rights under HIPAA as provided by Plastic Surgery Services.

Authorization for Communication:

- I authorize the office to contact me via phone (home, mobile, or work) regarding appointments or returning messages.
- I authorize appointment reminders or cancellation notifications to be left with a household member or voicemail.
- I authorize communication via text, email, or phone regarding appointments. These services are provided as a courtesy. I understand that this authorization does not permit the release of any confidential medical information.

Patient Name: _____

Signature: _____

Date: _____



HENRY F GARAZO MD

PLASTIC SURGERY SERVICES & MED SPA

Cosmetic Interest Form

Cosmetic medical services or procedures of interest to you

(please check all that apply)

Cosmetic Surgical Procedures:

- Breast Augmentation (Enlargement)
- Mastopexy (Breast Lift)
- Breast Reduction
- Abdominoplasty (Tummy Tuck)
- Gynecomastia (Male Breasts)
- Liposuction
- Face lift
- Blepharoplasty (Eyelids)
- Otoplasty (Ear Tuck)

Cosmetic Non- Surgical Procedures:

- Botox/Dysport Injection for wrinkles
- Injectable Fillers (Voluma, Juvéderm, Vollure)
- Kybella
- Chemical Peel (Face or Body)
- Microneedling (Regular or with PRP)
- PRX
- Dermaplaning
- Diamond Glow Facial
- Fire and Ice Facial
- Red Light Therapy Facial
- PRP for hair loss
- Skin care products (SkinMedica, SkinCeuticals, IS clinical, Skinade)

